

South Carolina Department of Health and Human Services

**NOTICE OF COST OF CARE
FOR MEDICARE SPONSORSHIP IN A NURSING HOME**

From:

Date: _____

Case Number: _____

To:

Recipient Name: _____

You were previously notified that your application for the Medical Assistance Only (MAO) - Nursing Home Assistance has been approved.

Please note the following IMPORTANT Information:

- ☐ We have been advised that Medicare is sponsoring your care at the nursing home effective _____. Medicare pays in full for services for up to the first twenty (20) days and partially from the 21st day up to the 100th day if all Medicare criteria are met. The Medicaid program is not responsible for the coinsurance amount due from the 21st day up to the 100th day. You are required to pay the nursing home _____ per month toward the cost of your care beginning _____. The nursing home will notify the Medicaid Office when your Medicare sponsorship ends and the Medicaid eligibility worker will determine if you meet the criteria for Medicaid to sponsor your care at the nursing home. We will notify you of our decision and the amount you will pay.
- ☐ Your eligibility for Nursing Home Assistance payment is based on having established an Income Trust. Your income, as listed on Schedule A of the trust, **must** be deposited into your trust account. Your cost of care is determined by subtracting allowable deductions from your gross income (regardless if listed on the Schedule A or not.) The allowable deductions are listed on the attached DHHS 1729, Income Trust Budget Sheet.

- ☐ Spousal Impoverishment Resource Provisions were used to determine your eligibility. To remain eligible, you must transfer all resources except \$2,000 to _____ within 90 days from the date on this notice. You must also provide verification of the transfers to your Medicaid eligibility worker.

Manual/policy reference supporting this action:

(A copy of the referenced material is available upon request from the DHHS)

- ☐ Fair Hearing:

If you disagree with this decision in any way, you have 30 days from the date of this notice to submit new information, or submit any information that we previously requested, in order to have your case reevaluated. If you believe we've made an error, you have the right to appeal this decision at a hearing with SCDHHS, the agency that administers Medicaid in South Carolina. You may represent yourself at the hearing, hire an attorney to help you or have someone speak on your behalf. You must submit a written request for a hearing no later than 30 calendar days from the date on this notice via one of the following methods:

- Appeal online at www.scdhhs.gov/appeals
- Mail your request to:
SCDHHS – Central Mail
PO Box 100101
Columbia, SC 29202-3101
Attn: Eligibility Appeals
- Fax your request to: 888-835-2086
- Or email your request to: eligappeals@scdhhs.gov. For your privacy and security, please note that mailing personal health information is more secure than email.

In your appeal request, you should specifically state which issue(s) you wish to appeal and attach a copy of the notification received from SCDHHS regarding the specific matter on appeal. For more information about the appeal process or what to include in your appeal request, go to www.scdhhs.gov/appeals, call 888-835-2039 (TTY 888-842-3620) or send an email to eligappeals@scdhhs.gov.

If you submit an appeal request within 10 days of the date on this notice, you may be eligible to continue to receive Medicaid benefits until a decision is made regarding your appeal. If you decide to continue receiving benefits during your appeal, you may be asked to repay any charges to your Medicaid account if the appeal decision is not in your favor.

- ☐ Report Changes:

Please tell your Medicaid eligibility worker immediately if you move or your address changes. If you have a change in income, resources or family size, or if you have new or additional information that would affect your case, you must notify your Medicaid eligibility worker within 10 days.

Notice of Non-Discrimination

The South Carolina Department of Health and Human Services (SCDHHS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCDHHS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCDHHS provides free aids and services to people with disabilities, such as qualified sign language interpreters and written information in other formats (large print, braille, audio, accessible electronic formats, other formats). We provide free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact Janet Bell, ADA and Civil Rights Official, by mail at: PO Box 8206, Columbia, SC 29202-8206; by phone at: 1-888-549-0820 (TTY: 1-888-842-3620); or by email at: civilrights@scdhhs.gov.

If you believe that SCDHHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Official using the contact information provided above. You can file a grievance in person or by mail or email. If you need help filing a grievance, we are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201 or by phone at: 800-368- 1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Language Services

If your primary language is not English, language assistance services are available to you, free of charge. Call: 1-888-549-0820 (TTY: 1-888-842-3620).

si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-549-0820 (TTY: 1-888-842-3620).

إذا كانت لغتك الأساسية غير اللغة الانكليزية فان خدمات المساعدات اللغوية متوفرة لك مجاناً. اتصل على الرقم:
 (1-888-842-3620) (رقم هاتف الصم والبكم 1-888-842-3620)

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-549-0820 (TTY: 1-888-842-3620).

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-549-0820 (телетайп: 1-888-842-3620).

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-549-0820 (TTY: 1-888-842-3620).

Se você fala português do Brasil, os serviços de assistência em sua lingua estão disponíveis para você de forma gratuita. Chame 1-888-549-0820 (TTY : 1-888-842-3620)

如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-549-0820 (TTY: 1-888-842-3620)

Falam tawng thiam tu na si le tawng let nak asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.

धयद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह । 1-888-549-0820 (TTY: 1-888-842- 3620) पर कॉल कर ।

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-549-0820 (TTY: 1-888-842-3620)번으로 전화해 주십시오.

Haka tawng thiam tu na si le tawng let asi mi 1-888-549-0820 (TTY: 1-888-842-3620) ah tang ka pek tul lo in na ko thei.

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-549-0820 (ATS : 888-842-3620).

နမူနာကတိ ကညီ ကျိအယိ, နမူနာ ကျိအတိမၤစၢၤလၢ တလံာ်ဘျုးလၢၣ်စ့ၤ နီတမံၤဘျုးသ့န့ၣ်လီၤ. ကိး
 888-549-0820 (TTY: 888-842-3620)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-549-0820 (መስማት ለተሳናቸው፡ 1-888-842-3620)፡

အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့် ငဲ့အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 888-549-0820 (TTY: 888-842-3620) သို့ ခေါ်ဆိုပါ။